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Indiana Early Childhood Comprehensive System Statewide Plan

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Overview

According to the report from the National Research Council and Institute of Medicine entitled, *From Neurons to Neighborhoods: The Science of Early Childhood Developmen*t (2000), "…early childhood programs that deliver carefully designed interventions with well-defined objectives and that include well-designed evaluations have been shown to influence the developmental trajectories of children…". The release of this seminal report provided the scientific evidence of the complexity of early childhood development and its importance in ensuring that children arrive at school ready to learn. In the years since the release of the report, additional reports and initiatives have reinforced and expanded these findings. The National Governors Association has focused on the importance of early childhood and it remains a major program initiative of the Association. The newly released report *Getting Ready: Findings from the National School Readiness Indicators Initiative, A 17 State Partnership s*ponsored by the David and Lucille Packard Foundation, the Kauffman Foundation and the Ford Foundation (February 2005) identifies key indicators that support early childhood initiatives as the mechanism for school readiness. The Minneapolis Federal Reserve Bank released a report that identifies the economic impact to a state's economy of focusing on the early childhood years. These reports and initiatives confirm what parents and the early childhood community has always instinctively known. The recent federal focus on young children and the critical importance of a "good start" for those children in developmental, educational and emotional areas underscores what policy makers in Indiana have been working toward for a long time.

For the past fifteen years, Indiana has demonstrated its commitment to improving the lives of young children and their families through participation in a variety of state and federal initiatives focusing on improving outcomes in early childhood. While considerable progress has been made toward the outcome of a more comprehensive early childhood system, stakeholders continue to strive for improvement. Indiana has engaged in a collaborative process involving participants representing relevant constituencies across the state in order to develop an Early Childhood Comprehensive Systems (ECCS) plan and implementation schedule that will lead to an enhanced coordinated, community-based system of services for young children. The strategies identified in the Indiana ECCS plan will increase coordination of resources; expand stakeholder awareness and access to necessary informational resources; support public and private partnerships and create a cross agency infrastructure for training and technical assistance.

The State of the Child in Indiana[1]

During the past decade Indiana has experienced a 9.7% increase in the general population. In 2002 there were 84,839 births. Of the total births, 7.6% were low birth weight (less than 2500 grams). Twenty percent of the total births were to women with less than 12 years of education. Over 36.5% of babies are born to unmarried mothers and 52% of children under 18 live in female headed households receiving child support or alimony. In 2002, 15.7% of Indiana households had at least one child with asthma. According to OMPP, of 23,161 children age 0-17 enrolled in Medicaid in 2003, 10% had an emergency room visit with principal diagnosis of asthma and 4% were hospitalized for asthma. Forty percent of children under age 6 are classified as low income.[2] Recent estimates show that 161,815 children (9.6%) in Indiana under age 19

[1] Data Sources include National Center for Children in Poverty, Indiana Youth Institute and the Indiana Business Research Center.

[2] Low income is defined as 200% of the federal poverty level.

were uninsured. The national uninsured percentage for the children under age 19 was 11.6 percent. Of the total uninsured in Indiana, 53.5% were eligible for Medicaid and 14% were eligible for SCHIP.[3] In addition, 10.2% of the CSHCN in Indiana were without health insurance at some point during the past year and 4.8% of the CSHCN are currently uninsured. Approximately thirty one percent of the currently insured CSHCN have coverage that is inadequate.[4]

Recognizing the impact of health behaviors during pregnancy on the outcome of a desired healthy baby at birth, and the impact of those behaviors on long term health and development, the ECCS initiative is also tracking data on Indiana births and outcome indicators. This data will be disaggregated by race and ethnicity because of the health disparity issues that exist in Indiana. The most recent data available on birth outcomes by race and ethnicity are contained in Attachment A.

The ECCS initiative is also tracking data for critical early childhood system components such as child care, Head Start, child abuse and neglect and Part C early intervention. Those data charts, spanning an eight year time frame, may also be found in Attachment A.

As a result of the newly released document *Getting Ready: Findings from the National School Readiness Indicators Initiative, A 17 State Partnership*[5], the Indiana ECCS initiative will also begin to identify the appropriate data source and track the key indicators identified in the report that "relate to and define school readiness."

Review of Current Best Practices

In recent years, much attention has been given to describing evidence-based best practices in early childhood. In 2000 the Committee on Integrating the Science of Early Childhood Development in its report *From Neurons to Neighborhoods* called for a renewed national dialogue regarding early childhood policy and practice. The ten core concepts[6] in the document highlight the complexity of early learning experiences and the "long reach" of childhood (Halfon, Russ, & Regalado, 2005, pg 5). Experiences, circumstances and situations encountered in early childhood are now known to have effects on health, development, behavior, school readiness, and socialization that were not well documented or understood in years past. Furthermore, researchers and service providers have long understood that children's development occurs across all domains simultaneously. To focus solely on one area is to likely miss important opportunities in another. This high level of interaction and overlap between important areas of child development should be matched by coordination between systems that support child and family development. Advocates of all disciplines must embrace the notion of

[3] American Academy of Pediatrics Division of Health Policy Research Analysis of a) 2004 March Demographic File, Current Population Survey, and b) Kaiser Family Foundation State Health Facts online. Income Eligibility Levels for Children under Medicaid/SCHIP as a Percent of Federal Poverty Level, April 2003.

[4] Child and Adolescent Health Measurement Initiative (2004). Children and Youth with Special Health Care Needs, Data Resource Center on Child and Adolescent Health Website. Retrieved 01/14/2005 from www.cshcndata.org.

[5] Sponsored by the David and Lucille Packard Foundation, the Kauffman Foundation and the Ford Foundation, February 2005 www.gettingready.org

[6] *From Neurons to Neighborhoods: The science of early childhood development.* 2004. The National Academy of Sciences. pp.3-4.

collaboration and interdisciplinary perspectives. Jack Shonkoff, MD in the Ounce of Prevention Fund publication *Science, Policy, and the Young Developing Mind,* succinctly captures the essence of integrating these concepts and urges the field to collaborate in quality, cost-effective early childhood resources, supports and services.[7]

Collaborative service delivery by early childhood professionals, such as health care and developmental counselors, can improve child outcomes. Halfon and Inkelas (2003) note that the promotion of health in the United States has resulted in remarkable changes in lifespan and functional capacity. In a national trial using an experimental design, which included a trained developmental specialist in pediatric primary care settings, researchers noted significant differences in health care outcomes. Children in the Healthy Steps group had access to more timely and appropriate services. Parents also adopted behaviors and strategies that decreased their children's health risks and increased their parenting skills. In reflecting on the outcomes of this project Halfon and Inkelas (2003) noted that "quality measurement for children cannot simply be based on the health care that is provided within the pediatric practice, but also must account for the quality of connections that clinicians make with resources in their community."[8]

Early care and education efforts for children birth to six encompass several initiatives including early intervention (Part C, IDEA), preschool education (including Part B, IDEA), Early Head Start, Head Start, and child care. A great deal of emphasis as well as increased funding has been directed toward these efforts at local, state and national levels. At the same time expectations for accountability of the expenditure of public dollars have increased. A number of long term evaluation projects have set out to address this question. Reynolds and Temple summarize the results of three such reviews that provide evidence of the cost effectiveness of early childhood programs. The three major studies reviewed include the High/Scope Perry Preschool Project, the Carolina Abecedarian Project, and the Chicago Child-Parent Centers. Each of these projects provided an enriched early childhood education experience with varying efforts to address child and family needs through collaboration with other existing community resources and supports. All of these projects have been able to demonstrate, through long term follow-up efforts, significant fiscal impact. These programs demonstrate a large return on investment; for every $1 spent on early childhood education efforts, the social benefit ranges from $4 to $10 in savings later in other programs including education, justice and healthcare. In addition, participants overall enjoy increased economic well-being as a result of involvement in early childhood education.

Based on these results, Reynolds and Temple (2005) offer some guiding principles for effective early childhood education. These include:

1. Offer early education at age three continuing into early grades.
2. Teaching staff should be trained and compensated well.
3. Education content should be responsive to children's varying and unique learning needs in preparation for school readiness.

[7] Shonkoff, J. (2004). Science, policy, and the young developing child: Closing the gap between what we know and what we do. *Ounce of Prevention Fund, Chicago, IL.*

[8] Halfon, N & Inkelas, M. (2003). Optimizing the health and development of children. *JAMA 290,* 23. pp. 3136-3138.

4. Comprehensive family services should be available to meet the diverse needs of children in their communities.
5. Commit to ongoing evaluation of program and cost effectiveness.[9]

Comprehensive early childhood programs must be sensitive to the advances in understanding brain development. Research demonstrates that an incredible amount of brain growth and development occurs during the first three years of life. One of the primary tasks of the infant is to develop useful connections in the brain that set the stage for future learning. These connections are shaped by many influences including consistent, warm and caring interactions with adults. Infants need secure attachments with caring adults. Those attachments form the foundation for early child development. Through these secure attachments, infants develop cognitive, physical, communication, and social-emotional skills (Breuer & Greenough, 2001).[10]

Many researchers have explored the mental health needs of infants and toddlers. Most children experience a healthy social environment as they begin to make sense of what is happening around them. A healthy attachment to a primary caregiver is essential for the infant and toddler to develop the necessary wiring for learning and life. Joy Osofsky, PhD in a statement before the Subcommittee on Substance Abuse and Mental Health Services Committee on Health, Education, Labor and Pensions recommended the following steps to ensure the mental health needs of infants and toddlers are addressed:

1. Strengthen infant and early childhood mental health services and integrate such services into all child-related services and systems.
2. Assure earlier identification and intervention of mental health problems and disorders in infants, toddlers and their parents.
3. Develop system capacity through professional development/training of service providers.
4. Assure comprehensive mental health services for infants and toddlers in foster care.
5. Provide infant/toddler child care programs with access to mental health consultation and support.
6. Support and advance evidence-based practices in infant and early childhood mental health through the establishment of a national infant mental health resource center.[11]

The ECCS initiative recognizes the current body of scientific evidence and its influence on policy and programs in the state of Indiana. This body of evidence has helped shape the Service Standards developed collaboratively by the various stakeholders in the strategic planning process. These Service Standards that guide the activities and strategies of the ECCS initiative are outcome focused, culturally competent and responsive, family centered, proactive and responsive, universally accessible and evidence-based.

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[9] Reynolds, AJ & Temple, JA. (2005). Priorities for a new century of early childhood programs. *Infants and Young Children 18*, 2. pp. 104-118.

[10] Breuer, J. T., & Greenough, W. T. (2001). The subtle science of how experience affects the brain. In D.B. Bilay, J. T. Brown, F. J. Symons, & J. W. Lichman (Eds.), Critical thinking about critical periods (pp. 209-221). Baltimore: Brookes Publishing.

[11] Osofsky, J. (2004). Statement before the Subcommittee on Substance Abuse and Mental Health Services, Committee on Health, Education, Labor and Pensions. ZERO TO THREE Policy Center (www.zerotothree.org/policy)

These standards guided the development of the outcomes, priority objectives and intervention strategies of the ECCS strategic plan described in detail later in this application. The stakeholders remain committed to implementing policy, programs and services that reflect current best practice and to promote the ongoing evaluation of early childhood efforts in Indiana.

Needs Assessment

To build on work already accomplished in Indiana and to ensure the coordination between all partner agencies and organizations, existing needs assessments were gathered from three sources: the Core Partners Steering Committee, members of the Core Service Component Subcommittees, and from twelve community dialogues conducted across the state.

- Core Partners

  The Core Partners shared needs assessments that had been completed by the agencies or organizations they represented. While not all of this information was specific to the birth to five populations, a number of relevant issues were identified:
  - There is insufficient quality, affordable child care accessible throughout Indiana. Urban areas have more child care opportunities than rural, however, access to child care at non-traditional hours is unavailable in both urban and rural areas of the state. Support for large and small facilities differs in terms of funding, education and technical assistance. Consistent regulations for all early care and child care settings are lacking. Families are not educated in what constitutes a quality child care environment. Training for child care providers is needed using a variety of methods to accommodate schedules including distance learning and mentoring and should be consistent across child care homes, centers and ministries. Primary child care providers lack education in developmentally appropriate practice across a wide spectrum of topics including, but not limited to: child development, infant and child mental health, attachment, behavior management, cultural competence and conflict resolution.
  - There are large numbers of uninsured children, children with no identified medical home, and children who do not receive well child/routine medical care or dental care.
  - Many parents are unaware of resources available, uneducated in the importance of early learning and often are unable to access the limited quality child care available.
  - There is a perceived lack of programming in parenting skills, nutritional skills, emotional well being and general information about social service and community resource information.
  - There is a lack of appropriate use of statistical data from evaluations to assess the outcomes of young children.
- Core Service Component Sub-committees

  The subcommittees identified areas in need of improvement in the identified priority area. A number of missing resources and services were identified as well as some that were not consistently available throughout all communities in the state. The information gathered though the sub-committee process substantiates the information gathered from other needs assessments and the work of the core partners.
  - Core Service Component 1: Access to insurance and medical home: Children and families are losing health insurance coverage unnecessarily due to repeated reapplications and lack of reporting changes in health insurance status. Medicaid no longer has ‘continuous eligibility’ therefore families are required to reapply more

frequently than annually and often do not. In addition, when families are determined ineligible and subsequently have a change in status that would make them eligible, they rarely notify health care providers of this change and are unaware of the consequences this may have on the type and quality of service they receive for their family. Many employers do not provide health insurance to families if they are working part time, and in the case of smaller businesses, insurance is not provided even if they are full time employees. Effective mechanisms to increase children's access and participation in CHIP and Hoosier Healthwise do not exist.

There is a need to define medical home consistently across all systems and ensure that those serving families are aware of the concept of medical home as defined for the Early Childhood Comprehensive System. More should be done to encourage medical providers to conduct regular comprehensive developmental assessments as part of well child visits. At the present time, health and medical providers struggle to fit such an assessment into the time and payment constraints of the visit. As a result they limit the number of screening questions asked and may not detect a problem that a more comprehensive assessment would have identified. There are cultural and language barriers to providing such assessments and most foster children, who frequently have a variety of challenges, are not getting appropriate assessments. The state Medicaid office may agree to payment for a developmental screening or they may not, resulting in confusion as to the effectiveness of submitting claims. Medicaid does not pay for "partial screening", giving the child only those sections of the assessment the health care provider believes are relevant to the child's presenting characteristics. Developmental screenings are classified as part of a well child visit and many commercial insurance plans do not cover routine or well-child care.When a developmental screening does reveal some issues, physicians lack information regarding where and how to refer families to appropriate community resources and supports for which they may be eligible.

- Core Service Component 2: Mental health and socio-emotional development: There are a limited number of trained mental health professionals and fewer for children under five and their families. Physicians, especially pediatricians and family practice doctors, do not have training on mental health issues and do not screen for these issues with parents. There is a lack of social work and psychology providers. Early intervention providers and preschool educators are not offering mental health services to families when there is a need for them. Education of these providers regarding effective, respectful presentation of mental health resources to families is needed. There is inadequate mental health consultation available to child care programs. There is little coordination of mental health and health care services as specialty care physicians do not typically coordinate their efforts with others involved with the family. There is no routine exchange of information between all service providers resulting in duplication and families encountering multiple providers unnecessarily or families not being served at all.

  Training in mental health and professional licensure requirements do not include infant mental health/social emotional developmental training. The training that does exist on this topic is not coordinated and offered sporadically throughout the state.

Early Periodic Screening Developmental Testing (EPSDT) is not uniformly used. Health insurance coverage for mental health services is likely to have limitations (caps, limits on visits) and families are often reluctant to access such services due to stigma attached to mental illness. In fact, parents most in need are least likely to access mental health services and when they do, they must go to many different places to access those services.

- Core Service Component 3: Early care and education: Quality standards differ across early care settings. A program's approach is determined by the funding received. There is a perception on the part of the care providers that the efforts to support high quality care are an invasion into the care providers 'business'. There are no standards for relative care as it relates to subsidized care. Indiana's child care classifications are not aligned with the National Health and Safety Standards and no financial support exists to meet these increased standards.

  Education of early care providers on the importance of early intervention and making referrals is time consuming and costly due. The intervention suggested for a child and family is difficult to implement in a child care setting.

  More serious and complex mental health issues in young children are being noticed at earlier ages. There are limited mental health resources to refer families to and there are insufficient training opportunities for early care educators and professionals on how to address social emotional issues in infants and young children.
- Core Service Component 4: Parenting education: Many programs ensure that families are educated about positive cognitive, social and emotional development for children, they are not available everywhere though parents may not be aware of programs that exist or the programs do not meet their needs.

  Funding for Parenting Education programs is limited and underutilized. Sometimes the rules to access funds are a barrier. While there are limited educational events designed specifically for parents, access remains a concern. Parenting education opportunities are not reaching underserved populations, fathers or those non-English speaking families. There is no clearinghouse of information or database that is universally accessible to parents regarding parenting issues, challenges or educational opportunities.
- Core Service Component 5: Family support: Funding stream "silos" create barriers to access for families seeking economic assistance. Eligibility varies and there is no coordination of application processes. Community resources available to families are not well known to all those working with families and/or the frequent contact information changes impedes access.

  While there are significant differences between urban and rural needs, little tailoring of programs to address those differences exists. Especially lacking are services for those families in the middle class. Increasing numbers of families have no health insurance and cannot afford to purchase it yet they do not qualify for state health insurance. Families who have contact with Child Protective Services (CPS) face significant barriers to receiving the assistance they need. Community providers

require education about the resources available to assist families. There are a limited number of foster families available and preventative services are limited in rural areas. There is inconsistency in how Healthy Families and similar community programs support a family involved with CPS. The Health Insurance Portability Accountability Act (HIPAA) and confidentiality issues are reported to prevent complete follow through and wrap around.

Providers and consumers require education to prevent the spread of inaccurate information and to help women address behaviors that result in poor pregnancy outcomes. There is a lack of cultural sensitivity toward pregnant women of color resulting in their not accessing adequate prenatal care. There is little support for families of pregnant teens.

- Community Dialogues
  Results of the needs assessment process from the community dialogues can be categorized into three common areas: early care and education, health; and parenting education/awareness.
  - Early care and education: Participants lack affordable, quality child care. Child care is minimal for children who are ill or have special needs and during non-typical hours. Some communities do not have Early Head Start programs and report lack of child care centers serving low income families and lack of "slots" in Title I preschools and Head Starts. Early education programs, preschools or programs in licensed facilities were too expensive for most families or they lacked transportation.
  - Community dialogue participants identified a lack of health insurance for children and families despite their eligibility for available programs such as Medicaid (Hoosier Healthwise) and CHIP. Lack of awareness of resources and bureaucratic red tape exacerbates the problem. Health care providers' hours do not meet the needs of families for access outside of the hours of 9:00 am and 5:00 pm. Doctors were reported as not referring families early enough and misdiagnosing needed care. Families were reported as not being aware of the importance of good dental and eye health and early prenatal care. Waiting lists for waivers, special education evaluations, therapists and specialists indicate limitation of some resources.
  - Parenting Education and awareness issues include the complexity of accessing and navigating the system; making it difficult for families, to obtain the services they need. There is a general lack of parenting education. The impact of low self esteem of parents in general was reported. Parent support opportunities are limited and families are frequently unaware of those that do exist. The general public is not aware of the importance of the early years and the role of the family.

Summary

The themes common to all priority subcommittees were collapsed across five areas: capacity, funding, application process, training/education and coordination. It is important to note that a shortcoming in one area has an effect on each of the others so careful consideration of suggested solutions is necessary to ensure the coordination across all themes.

- Capacity: Program quality is inconsistent. There were rural and urban differences, high staff turnover and a lack of developmental physicians to meet the needs of the population. The lack of leadership around early childhood issues was reported.

Participants commented on the perceived lack of a children's champion at the state level.

- Funding. All groups identified disparities in funding and limited resources in general with no funding for preventative or well child care. Funding streams are not coordinated. Programs that had continuous eligibility policies now do not resulting in additional effort on the part of families to re-apply and increased work on the part of staff to review the applications. There is a lack of resources to support the state and federal requirements of the programs that are available.
- Eligibility Process. The loss of continuous eligibility complicates the process and makes access of services, resources and supports difficult. The requirement of repeated applications and the complexity of the applications do not make the process user friendly. Some programs change their eligibility with little notice to families or even staff. Program rules are subject to change without an effective way to communicate those changes.
- Training/Education: Early childhood educators and providers need opportunities to learn more about current best practice and resources available in their communities. Referral sources need opportunities to learn about the available resources and how to better connect families with the programs that would be of benefit to them. Priority topics for training are professional licensure requirements, early childhood social emotional issues and cultural sensitivity. Families also need of training and education opportunities especially in the importance of prenatal care and early care and development. Barriers to training include variations in literacy levels of those being trained, reduction in funds to support training efforts, lack of coordination of various training efforts and lack of a common language and definitions across those disciplines and systems working together.
- Coordination: Timely and accurate access to resources is not possible without a comprehensive information clearinghouse including a database of existing resources and supports. The transition between programs is difficult, hampered in part by HIPAA hysteria and lack of information exchange between the receiving and sending systems.

Current Early Childhood Initiatives

The following chart documents current initiatives within the early childhood community. These initiatives are organized by the five core ECCS service components. There will be duplication of resources as appropriate across the five core service component areas.

Table 1: Early Childhood Initiatives

Access to Health Insurance / Medical Home	Family Support	Parenting Education	Early Care and Education/Child Care	Mental Health and Social Emotional Development
American Academy of Pediatrics – website	Variety of local support groups on various themes	Family Information Center provides info to families on	CCDF (Child Care Development Fund) Voucher	INAssociation for Infant and Toddler Mental Health sponsors

Medical home signature required on IFSP Indiana Perinatal Network Medical Passport for Foster Children Combined enrollment form for First Steps early intervention system, Children's Special Health Care Services, Medicaid and MCH programs Medicaid – set of 5 questions to be used at enrollment to key MD into possible children with special health care needs Developing computer-based screening questions for parents to do before seeing physician	Family to Family organization supported by First Steps (Early Intervention Sys.) Relatives as Parents (RAP) effort Rural communities have multiple access points to connect to services Efforts to implement wrap around services to work with the families to access services; some counties, via referrals from OFC from providers working out of local mental health centers Families going in to DFC office can apply for other services including TANF, Food Stamps, Hoosier Healthwise (Medicaid), Housing	resources Children's Rights Council of Indiana Parents as Teachers (PAT) Indiana's Transition Initiative Indiana School for the Deaf (Parent Outreach Program) Fathers and Families Resource Center Regional Parent Resource (RPR) Provides info to families re: special education Family to Family network of support for families in early intervention system Partners in Policy Making training for families Better Baby Care Faith Based Organizations Mothers of Preschoolers Mothers of Multiples	Dollar provider eligibility State Regulations for centers and homes Non-formal CDA (Child Development Associate credential) Annual early childhood statewide conference sponsored by Indiana Association for the Education of Young Children (IAEYC) Indiana Child Care Health Consultant Program Facility Based Accreditation Project Indiana Partnership for Inclusive Child Care – efforts to increase the availability of inclusive child care Better Baby Care –program of Child Care Resource and Referral Agencies Child Care and Adult Food	task force on personnel development and a mentorship training program Mental health screening initiative – all children in foster care to be screened. Collaboration with FSSA/CPS, DMHA Child Care $ training of direct care providers on early mental health screening and referral Success by Six (United Way) Training opportunities for families and providers including overview of mental health and 12 month mentorship training program for early childhood providers. ENRICH (Early Intervention Resources and Information Curriculum Handbook)

EPSDT – efforts to ensure every child on Medicaid receives this assessment Prescreens questions completed by families enhances the medical visit	Assistance Partnering with Child Care Services Combined enrollment form for First Steps early intervention system, CSHCS, Medicaid and MCH programs	Head Start/Early Head Start Healthy Families Child Care Health Consultants	Program – subsidized nutritious meals for low income children Project Braintree – focus is Science and Math and expanding to literacy funded by Indiana Child Care Fund (ICCF)	Child Development Certificate) includes mental health in Competency III

Stakeholder Participation

As a beginning step in implementing the ECCS planning process, Indiana convened the Core Partners group to provide oversight and policy direction in the development and implementation of the ECCS strategic planning process. The Core Partners included members from key stakeholders at decision making levels including families, state agencies, professional trade associations, child advocacy organizations, and public and private early childhood providers.[12] Core Partners met regularly and provided input on the development of a vision, mission, service standards, desired outcomes, and issue identification for the ECCS initiative. Additionally, five subcommittees were established to address the project's five focus areas, which include: access to health insurance and a primary medical provider; mental health and socio-emotional development; early care and education; Parenting Education; and family support. Over 100 individuals from a wide spectrum of perspectives participated in subcommittee activities.[13] These smaller work groups identified unmet needs in each of the focus areas, provided input to documents drafted by the Core Partners and identified potential strategies to address the identified needs.

Twelve Community Dialogues were conducted in late August and early September 2004 in six different locations throughout the state. Two meetings were scheduled at each location at different times to ensure the broadest range of attendees possible. The meetings were open to anyone with an interest in meeting the needs of young children and their families in Indiana. Over 170 parents, caregivers, child care workers, health professionals, etc. participated in the dialogues. Discussion focused on how people felt about services for families in their communities. It was equally important to identify what current initiatives are effective and what areas need improvement.

In addition to the results of the community dialogues, all draft materials were posted on the Indiana State Department of Health, ECCS web page to encourage a transparency of process and to facilitate public input from the state and local level. The address for the ECCS web site is

[12] A listing of the Core Partner affiliations can be found in Attachment C.
[13] A listing of subcommittee affiliations can be found in Attachment C.

http://www.in.gov/isdh/programs/mch/eccs/eccsindex.htm. The final stage of stakeholder input came through three focused planning groups convened in January 2005.

Data from the Core Partners, five Subcommittees, Community Dialogues, focused planning groups and web-based input have been considered in producing this strategic implementation plan. The plan identifies specific strategies for moving toward an integrated, coordinated, comprehensive system of resources and supports for young children and their families. The coordinated system will ensure ease of access to needed services, increase the utilization of appropriate services and support the role of the family as a child's first teacher. The ECCS initiative will ensure such a comprehensive system of resources and supports are available to every young child in Indiana and that every child arrives at school ready to learn.

Role of Families

Families have been an integral part of the planning process for the ECCS initiative. Indiana has maintained its commitment to family involvement by ensuring parent involvement at all levels of the planning process including membership on all of the subcommittees and on the Core Partners group. Indiana committed 10% of the ECCS budget in each planning year to support family involvement. In addition, Indiana developed a mentoring process with the explicit purpose of engaging both experienced family advocates as well as new family advocates. Following an established protocol, new families were linked with experienced family advocates to provide support and mentoring in order to engage meaningfully in the committee process. A wide variety of organizations were contacted to identify potential family participants. Participation of families in the Core Partners group and subcommittees represented 20% of the total participants.

Vision, Mission and Service Standards

The Core Partners developed a draft vision, mission and service standards for the ECCS initiative. The draft document was provided to the five subcommittees for their comments. All comments were reviewed by the Core Partners and then by the Focused Planning Groups. The document reflects the best thinking of the broad stakeholder participants. The document will remain in draft form through the final public hearing process, one of the initial steps in the implementation of the strategic planning process.

Vision: In Indiana, children are safe, healthy and reach their full potential.

Mission: The ECCS Core Partners are leaders in the implementation of coordinated systems of care for young children birth through five and their families.

Guiding Principles/Service Standards: All activities and strategies employed through the ECCS initiative must align with the following core service standards:

- Outcome Focused – The design, delivery and evaluation of the early childhood comprehensive system of resources and supports will result in measurable benefits for the child, their family and the early childhood system.
- Culturally Competent and Responsive – A culturally competent early childhood comprehensive system will recognize and respond to the diversity of individual families. Resources and supports of the comprehensive system will accommodate and encompass all aspects of diversity including language, education level, geographic location, socio-economic

status, religious affiliation, ethnic and racial customs, as well as individual families' needs and priorities.

- Family Centered – Indiana's early childhood comprehensive system will recognize families as full partners in the design, delivery and evaluation of resources and supports. Family preferences for early childhood resources and supports will be identified and accommodated.
- Proactive and Responsive – Early childhood resources and supports are prevention focused. The system is responsive to research findings and economic changes, is fiscally responsible and promotes continuous systemic measurement and analysis of data and evaluation.
- Universally Accessible – All young children and their families, regardless of their ability to pay or their place of residence, will have access to quality resources and supports. The resources and supports will be coordinated across systems and will be inclusive and culturally competent.
- Evidence Based – Evidence based practices that employ the best available research and encompass professional wisdom and experience will be utilized throughout the early childhood system. Early childhood practitioners will incorporate the current best evidence related to resources and supports for young children and their families. Evidence encompasses a spectrum of data that includes:
    - Relevant, valid research from primary and secondary sources that is published in peer-reviewed journals or reviewed government research reports that indicate positive outcomes for children;
    - Empirical evidence derived from survey, descriptive, or qualitative research published in peer-reviewed journals (or secondary sources with the original citations) or in reviewed government research reports in the public domain that indicate positive outcomes for children related to a practice;
    - Multi-authored position statements or other multi-authored documents in the public domain that indicate consensus about the efficacy of a practice; and
    - Individual clinical experience.[14],[15]

<u>Outcomes:</u>

- Young children birth through five and their families are a policy, program and resource priority.
- Every family with young children birth through five has access to quality, comprehensive resources and supports.
- Resources and supports for young children birth through five are coordinated, cost effective, culturally and linguistically competent, and community based.

<u>Priority Objectives across All Outcomes</u>

- All children in Indiana will have a medical home.
- All children will be covered by a source of payment, whether public or private, for medical and developmental services that are identified by the medical home.
- The medical home will facilitate developmental, behavioral and mental health screening with appropriate treatment and referrals to community resources.

[14] O'Rourke, Wisdom Project 1997
[15] NAEYC, Working Definition of Evidence Based

- A central clearinghouse will be established that includes information about resources and supports at the state and local level for families of young children and providers of early childhood services.
- Quality resources and supports are integrated to create a coordinated, accessible early childhood system.
- Parents have the necessary information, support and knowledge about child development and are able to recognize their child's progress.
- Families have timely access to resources and supports to address their child's health, safety and developmental needs.

Strategic Implementation Plan

The following charts provide the work plan for implementation strategies that have been identified to support the achievement of the Priority Objectives. The detailed steps and timeline are included as Attachment D.

Table 2: ECCS Priority Objectives

Priority Objective 1.0: All children in Indiana will have a medical home.		
Strategies	Participating Entities	Measurement
1.1 Child Care Voucher applications will be revised to include a request for medical home information for each child who receives subsidized care.	• Bureau of Child Development • The Office of Medicaid Policy and Planning • Maternal and Child Health	• # and % of children under age 5 with: medical homes • Rate of early enrollment in Part C/CSHCS • # and % of parents able to identify primary care provider for their child(ren) • Rates of preventable morbidity
1.2 Children who are in the foster care system will have a medical passport.	• Maternal and Child Health • Department of Children's Services	• # of foster families using medical passport with primary care providers • Utilization rates for pediatric primary and specialty care services
1.3 Children screened for mental health and/or seeking immunizations will be asked if they have a medical home.	• Maternal and Child Health • Family Practice, Community Health Clinics, and Pediatricians • Department of Child Services • Division of Mental Health and Addictions	• Immunization rates • # and % of children receiving developmental and behavioral screening by primary care provider • Consumer satisfaction rates re: cost, location and access to resources and supports
1.4 The development of a universal application form will include information on a medical home	• ISDH/MCH • Core Partner State Agencies	• # and % of children receiving dental care • Utilization rates for pediatric primary and specialty care
Priority Objective 2.0: All children will be covered by a source of payment, whether public or private, for medical and developmental services that are identified by the medical home.		

Strategies	Participating Entities	Measurement
2.1 The Child Care Voucher Application process will support access to Hoosier Healthwise (Medicaid/SCHIP).	• The Office of Medicaid Policy and Planning • Maternal and Child Health • Bureau of Child Development	• # and % of children enrolled in Hoosier Healthwise • # and % of uninsured children under age 5 • # and % of uninsured children under 200% of federal poverty level • # and % of uninsured children over 200% federal poverty level
2.2 The combined enrollment process utilized by Early Intervention, MCH and CSHCS will be strengthened to include questions related to Hoosier Healthwise recertification.	• Bureau of Child Development • The Office of Medicaid Policy and Planning • Maternal and Child Health	• # and % of eligible children in Hoosier Healthwise • # and % of eligible families in SCHIP
2.3 CSHCS will develop a web application for enrollment	• Children with Special Health Care Needs	• # and % of eligible children in CSHCS • # and % of families that apply for CSHCS
2.4 Indiana will adopt a universal application process for enrollment in early childhood supports and services	• Core Partners	• # and % of families that apply for Hoosier Healthwise, CSHCS, WIC, SCHIP • # and % of eligible families in Hoosier Healthwise, CSHCS, WIC, SCHIP • # and % of families eligible for multiple enrollments who are dually enrolled
Priority Objective 3.0: The medical home will facilitate developmental, behavioral and mental health screening with appropriate treatment and referrals to community resources.		
Strategies	Participating Entities	Measurement
3.1 Young children will be screened for social emotional development status.	• Bureau of Child Development • Child care and mental health providers • Healthy Families • CPS/Foster Parents • Indiana Association of Infant Toddler Mental Health	• # and % of children screened for social emotional development • # and % of children enrolled in Medicaid who are assessed for social-emotional development through the EPSDT program. • # and % of providers providing developmental and behavioral screening for children under the age of 5

		• # and % of young children expelled from early care or early education settings due to behavioral problems
3.2 An outreach program to providers will be implemented statewide regarding the information clearinghouse of community resources to enhance appropriate referral/treatment.	• IN State Dept of Health • Indiana Institute for Disability and Community • IN Parent Information Network • Riley Hospital for Children • IN*SOURCE • Indiana Association for Infant and Toddler Mental Health • Mental Health Association in Indiana • Indiana Perinatal Network	• # and % of children who are referred for and use services for social emotional problems identified through EPSDT, well child visits or other routine, preventative care • # and % of parents screened for mental health needs • # and % of mothers who received information on postpartum depression • # and % of parents referred for mental health services
3.3 Personnel preparation efforts will be increased to recruit qualified early childhood mental health providers.	• IN Association for Infant Toddler Mental Health IN Dept of Education • Maternal and Child Health • Family Social Services Administration • University and College programs	• # of mental health providers trained to work with young children • # of professional development opportunities offered throughout the state • # of post secondary programs designed specifically to train mental health providers to work with young children
Priority Objective 4.0: A central clearinghouse will be established that includes information about resources and supports at the state and local level for families of young children.		
Strategies	Participating Entities	Measurement
4.1 The Early Childhood Meeting Place web site will be expanded to include families.	• IN Institute on Disability and Community • First Steps • IN State Dept of Health	• # of hits to Early Childhood Meeting Place • # of hits to links listed on Early Childhood Meeting Place • Rate of consumer satisfaction with use of clearinghouse information • #of resources listed in the clearinghouse
4.2 A Universal Application will be developed as a resource on the Early Childhood Meeting Place to	See 2.4	See 2.4

allow providers and families access to information regarding the public support systems they may be eligible for.		
Priority Objective 5.0: Quality resources and supports are integrated to create a coordinated accessible early childhood system.		
Strategies	Participating Entities	Measurement
5.1 The Core Partners will continue to guide ECCS activities.	• State Agencies • Provider Organizations • Advocacy Organizations • Parents • Insurance Companies • Civic Organizations	• # of state and local agencies, organizations and facilities represented in Core Partner membership • # of family representatives guiding ECCS activities
5.2 Core Partners will promote leadership within their respective agencies and organizations	• Core Partners	• # of Core Partners at meetings; leadership development events • # of participants from Core Partner agencies involved in ECCS activities
5.3 Indiana will implement a Universal Application.	See 2.4	See 2.4
5.4 Coordinate training and technical assistance.	• Maternal Child Health • IN Dept of Education • Unified Training System Partners • Child Care Health Consultants • Child Care Resource and Referral • Head Start • Healthy Families	• Parent knowledge of elements of high quality, developmentally appropriate care increases • # of training opportunities for developmental and behavioral screening in early child care/education settings • See 4.0, 6.0 and 7.0
5.5 National Quality Standards will be implemented in early care settings.	• IN Dept of Education • Child Care Resource and Referral • Maternal Child Health • Family Social Service Administration • IN Institute on Disability and Community	• # and % of single parent families with infants and young children whose co-pay for subsidized child care is 10% or more of income • # of licensing rules follow recommendations for SIDS prevention and incorporate Standards in “Stepping Stones to Caring for our Children” • # and % of children in licensed child care/preschool facilities • # and % of children in accredited child care/preschool

		facilities • Caregivers' Education level • Adult to child ratio • # and % of CSHCN enrolled in early care and education settings
Priority Objective 6.0: Parents have the necessary information, support and knowledge about child development and are able to recognize their child's progress.		
Strategies	Participating Entities	Measurement
6.1 Selected resources about child development will be used with and by parents to educate families about child development.	• Core Partner Agencies and Organizations	• Parent knowledge of child development milestones • Enrollment in parenting classes • Parent knowledge and parent-child relationship before and after participation in parenting education classes
6.2 Create electronic version of a developmental calendar for children 0-5	• Maternal Child Health • IN Institute on Disability and Community	• # of hits to calendar link
6.3 The Early Childhood Meeting Place will be marketed as a central source of information about child development.	• See 4.1	• See 4.1
6.4 Families have a meaningful role in the development of policies and programs at the state and local level.	• Maternal Child Health • IPIN • Family to Family Network	• # of parents on committees, task forces, boards at both local and state level • # of parents holding paid positions in early childhood
Priority Objective 7.0: Families have timely access to resources and supports to address their child's health, safety and developmental needs.		
Strategies	Participating Entities	Measurement
7.1 The Early Childhood Meeting Place will maintain current information about resources related to children's health safety and development.	• Maternal Child Health • Indiana Institute on Disability and Community • Core Partners	• # of community resources • Utilization rates of resources included in database
7.2 Child Care Health Consultants will educate child care providers regarding health, safety and development.	• Maternal Child Health • IN Child Care Resource & Referral • Bureau of Child Development	• Health and dental care utilization rates • % children fully immunized by age 2 • # and % of eligible women, infants and young children

		enrolled in WIC and other relevant programs • Rates of child abuse and neglect • Injury rates of young children • # and % births to teens • # subsequent births to teens • # and % children under 5 in single parent households
7.3 Training and technical assistance will be readily available and affordable to families throughout the state.	• IN Dept of Education • Maternal Child Health • IN State Dept Health • FSSA • Healthy Families • IN Parent Information Network • Regional Resource and Referral contacts • Community Health Clinics	• # of parenting education and support programs for families including families of children with special needs and non-traditional families • Enrollment in parenting education programs • # of home visiting programs that incorporate parenting education • # and % parents reporting receipt of early literacy information
7.4 Training and technical assistance will be provided to those serving young children and their families.	• IN Dept of Education • IN State Dept Health • FSSA • Healthy Families • Regional Resource and Referral contacts • Community Health Clinics	• # of training events • #of participants at training and educational events • # events targeted at rural communities • Variety of delivery methods for training (distance ed, web)
7.5 The application process for resources and supports will be efficient so families are able to access the resources and supports they need in a timely manner.	• See 2.4	• See 2.4

Evaluation

Three outcomes have been identified for Indiana's early childhood comprehensive system (ECCS) with seven corresponding priority objectives to achieve those outcomes. Those involved in the development of the plan represent the broadest array of state and local organizations and agencies and each of the stakeholders has questions about its effectiveness. The evaluation plan for this work effort will employ both qualitative and quantitative data collection and analysis procedures at multiple levels of accountability. Indicators have been identified for each of the priority objectives as well as the corresponding implementation strategies as measures of effectiveness. Most of this information is already collected to fulfill state and federal reporting

requirements including: Early Intervention Part C Annual Performance Report, Maternal and Child Health Title V Block Grant, MCH Needs Assessment Priority Survey, Head Start, Indiana Department of Education December 1 Child Count, among others. Some of the questions that these data indicators will answer follow by level of accountability. Additional questions that emerge during the implementation phase will be addressed as determined appropriate by state MCH staff and the Core Partners.

Level 1. The discrete activities detailed in the strategic plan will be monitored for completion and efficacy. Did Indiana do what the plan said? How much was done and for which target audiences? Were the project activities completed on time? Were there any unforeseen influences that caused modifications to the plan? What were the positive and negative implications of those modifications? Is there a concerted effort on the part of all stakeholders to work together and integrate resources and supports for families? How could the implementation be improved?

Level 2. The second level of evaluative activity will determine whether or not any Indiana families are better off as a result of the implementation of the ECCS. Did the activities make it possible for more families to access quality comprehensive services? Are Indiana children healthy safe and ready to learn? Do more families have an identified medical home where they are covered by a public or private source of payment for their care? Are more families able to access the resources and supports they need when they need them? Are there fewer reports of child injury, neglect and abuse? Are families able to access timely information about child development, physical and mental health, and safety?

Level 3. The third level of evaluation will focus on how well Indiana implemented the strategic plan. When compared to the baseline data, is there evidence that the implementation of the ECCS made a difference at the individual level, at the community level and at the state level? Are resources being used more efficiently and without duplication? Are services coordinated, cost effective and community based? Is there more opportunity for improvement? How could Indiana go about sustaining the effort commenced with the implementation of the current strategies?

Attachment A: Data Charts

2002 Indiana Births and Outcome Indicators by Race and Ethnicity of Mother					
All Races / Ethnicities		Race		Ethnicity	
Total Births	Total	White	Black	Non-Hispanic	Hispanic
Total Indiana Births	84,839	74,013	9,243	78,346	6,145
All Races / Ethnicities		Race		Ethnicity	
Outcomes as a Percent of Births	Total	White	Black	Non-Hispanic	Hispanic
% Low Birth Weight	7.6	6.9	12.9	7.7	6.3
% Very Low Birth Weight	1.4	1.2	2.6	1.4	1.2
% Preterm	9.4	9.0	12.5	9.5	7.7
% PNC First Trimester	80.5	82.1	68.6	81.9	63.9
% Used Alcohol During Pregnancy	0.7	0.7	1.5	0.8	0.5
% Smoked During Pregnancy	19.1	19.9	15.2	20.2	4.2
% Unmarried Parents	36.5	31.9	76.5	35.5	49.7
% Mothers Under 20 Years Old	11.4	10.5	19.9	11.2	13.9

Early Childhood System Components Data								
	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
# of Births	82917	83157	83385	85055	85489	87697	86122	84839
# of children 0-4	409687	409635	407103	410739	413675	423215	426466	429345
%of Low Birth Weight Babies	7.5	7.6	7.7	7.9	7.82	7.3	7.6	7.6
Child Abuse and Neglect Deaths	44	43	46	65	41	44	45	69
Abuse and Neglect Rate	18.1	15.9	12.4	10.8	13.9	16.1	14.7	12.7
Licensed Child Care Slots	NA	86140	88481	93967	96821	102729	107823	110122
Number of Head Start enrollees	NA	NA	11926	11829	11170	12678	NA	NA
Number of First Steps (Part C) enrollees	7211	8075	8856	10857	13338	16548	15318	17946
# of CSHCN enrollees	1924	2116	2853	3521	4816	5289	5841	6148
Number of Public School Preschool children with disabilities	8355	9100	9332	9876	10499	11069	11616	12612

Attachment B
Stakeholder Affiliations

Core Partners Organizations (37 members): Parents, IN Minority Health Coalition, Office of Medicaid Policy and Planning, IN Child Care Fund, Indiana Perinatal Network, Hancock County Step Ahead, Division of Mental Health and Addiction, Department of Education, Division of Exceptional Learners, Healthy Child Care Indiana, IN Institute for Disability and Community, Early Childhood Center, IN Department of Environmental Management, Bureau of Child Development, Division of Family and Children, IN Academy of Family Physicians, IN State Department of Health, Juvenile Justice Association, IN Chamber of Commerce, IN Department of Corrections, IN Latino Institute, IN Head Start Association, Indiana Parent Information Network, Riley Child Development Center, The Commission on Hispanic/Latino Affairs, IN Child Care Resource and Referral, IN Chapter, American Academy of Pediatrics, IN Association for the Education of Young Children

Access to Insurance/Medical Home Subcommittee (19 members): Parents, Office of Medicaid Policy and Planning, Indiana Parent Information Network, Riley Hospital for Children, Indiana Perinatal Network, Bureau of Child Development, Indiana State Department of Health, Indiana Latino Institute, Covering Kids and Families, Indiana Academy of Pediatrics

Infant Mental Health Subcommittee (22 members): Parents, Bureau of Child Development, Hamilton Center, Ball State University, Indiana Head Start Partnership, Private Mental Health Provider, Transitions, Texas Migrant Council, IU School of Nursing, Indiana Child Care Resource and Referral, Healthy Families, Indiana Women's Prison, Tri City Mental Health Center, Division of Mental Health and Addiction, Riley Child Development Center, St. Vincent Hospital

Early Care and Education Subcommittee (26 members): Parents, Indiana Department of Education, Auntie Mame's Child Development Center, IN Institute for Disability and Community, Child Care providers, Day Nursery, American Indian Center of Indiana, Indiana Head Start Partnership, Purdue University, Indiana Head Start/Early Head Start, IN Association Child Care Resource and Referral Agencies, Indiana Parent Information Network, Indiana Association for the Education of Young Children, Bureau of Child Development, Region V Head Start Quality Network

Family Support Subcommittee (20 members): Parents, Grandparent, Mom Project, Family and Social Services Administration, Step Ahead, Vigo County Health Department, WIC/Marion County Health Department, United Way of Central Indiana, Division of Mental Health and Addictions, Circle Around Families, Children's Health Insurance Program, Family Health Services, Community Health Center, Decatur County Office of Family and Children, Indiana Association of United Ways, Indiana Perinatal Network, Social Worker/Education Administrator

Parenting Education Subcommittee (23 members): Parents, Parent Information Distribution Center, Early Childhood Alliance, IN*SOURCE, Planned Parenthood of Greater Indiana, Division of Mental Health and Addiction, Riley Hospital for Children, Bureau of Child Development, , IN Association Child Care Resource and Referral Agencies, IU School of Nursing, Indiana Head Start, Family Voices, Covering Kids and Families, Family to Family, Purdue University,

Focused Planning Groups (53 participants): Parents, IU School of Optometry, CHIP/Medicaid, Indiana Parent Information Network, Vigo County Health Department, Easter Seals Crossroads, Child Care Fund, South Bend Memorial Hospital, Pecar Health Center, United Way, Indiana Perinatal Network, Bureau of Child Development, Department of Education, Healthy Child Care Indiana, Indiana Department of Environmental Management, Anthem Blue Cross Blue Shield, Auntie Mame Child Care, Day Nursery, Family Development Services/Head Start, Minority Health Coalition, Riley Hospital for Children, Porter Starke Services, Central Indiana First Steps, IN Association of Child Care Resource and Referral Agencies, Healthy Families, Community Coordinated Child Care, Continuum of Care/Drug Free Gary, Indiana 211 Partnership, Minority Health Coalition, Covering Kids, Division of Mental Health and Addiction, Welborn Foundation, Purdue University, Indiana Association for the Education of Young Children, Riley Child Development

Groups Contacted for Potential Parent Participants (15): Child Care Resource and Referral, Core Partners, Flanner House, Foster Parents, Head Start, Indiana Home School Association, Moms Club of Indiana, Moms of Preschoolers, Parents as Teachers, Parents of Children with Special Needs, Parents of Typically Developing Children, Relatives as Caregivers, Riley Hospital for Children, Community Education, St. Mary's Child Center